No. 10-20868

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

ACCESS MEDIQUIP L.L.C.,

Plaintiff-Appellant,

v.

UNITEDHEALTHCARE INSURANCE COMPANY,

Defendant-Appellee.

On Appeal from the United States District Court
For the Southern District of Texas, Houston Division
No. 4:09-CV-02965

BRIEF OF THE SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT

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QUESTION PRESENTED

Whether ERISA preempts a service provider's state law claims against an ERISA plan's insurer for negligent misrepresentation, promissory estoppel, and violations of the Texas Insurance Code.

THE SECRETARY'S INTEREST

The Secretary of Labor bears primary responsibility for interpreting and enforcing Title I of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 698 (7th Cir. 1986) (en banc). In this capacity, she has a strong interest in ensuring that courts correctly construe the scope of ERISA preemption. In prior ERISA preemption decisions, this Court has expressly considered the view of the Department of Labor as expressed in amicus briefs and may find the Secretary's views helpful in resolving the preemption issue here. E.g., Arana v. Ochsner Health Plan, 338 F.3d 433, 437 n.6 (5th Cir. 2003) (en banc).

STATEMENT OF THE CASE

Plaintiff Access Mediquip, LLC ("Access") supplies medical devices to healthcare providers. Am. Compl. at ¶ 14. Typically, providers ask Access to furnish a medical device before the procedure using the device is performed. Id. Rather than sell the device to the provider, Access contacts the patient's insurer to confirm that the insurer will reimburse Access for the device and pay for Access's

services. Id. at ¶ 19. Access generally refuses to procure or finance a device if the insurer tells Access that the patient is not covered, that the device or procedure is not covered, that pre-certification of the device is required and has been denied, or that Access may not directly bill the insurer for the device. Id. at ¶ 58.

In this case, Access sued defendant-insurer UnitedHealthcare Insurance Company ("United") with respect to alleged misrepresentations concerning coverage and payment for Access devices for over two thousand patients covered by numerous health care plans. Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co., 662 F.3d 376, 377 (5th Cir. 2011) (panel decision). The district court limited the summary judgment motions to three "test" cases that would serve as exemplars. Id. at 378.

In each of these test cases, the patients obtained United's health insurance through participation in an ERISA health benefits plan. Access Mediquip L.L.C. v. UnitedHealth Group Inc., Case No. H–09–2965, 2010 WL 3909544, at *1 (S.D. Tex. Oct. 4, 2010) (district court decision). The facts of these cases are similar: a hospital asked Access to procure or finance a medical device for an operation. Id. When Access contacted United, a representative assured Access that the patient was covered and authorized Access to bill United directly for the device. Id. After Access provided the device for the procedure, United concluded that the applicable

ERISA plan did not cover the procedure requiring the device and thus refused to fully pay for the device. Id. at *1-*3.

The State Law Claims and Decisions Below

Access's state law promissory estoppel, negligent misrepresentation, and Texas Insurance Code claims "are premised on its allegations that it provided its services for [the three test cases] in reliance on United's representations regarding how much, and under what conditions, United would pay Access for those services." Access Mediquip, 662 F.3d at 379; see Compl. at ¶¶ 18-19. Access does not challenge United's conclusion that the patient lacked coverage under the terms of the applicable ERISA plan, and thus is not relying on assignments from the patients of their rights to receive plan benefits.[1] Instead, it is challenging United's decision not to pay after giving Access authorization to supply the devices.

The district court granted summary judgment for United on all state law claims relating to the three "test cases." Access Mediquip, 662 F.3d at 380. The court acknowledged "that ERISA does not preempt state law causes of action when

[1] See Access Mediquip, 2010 WL 3909544, at *3 ("Access does not allege that United's representations regarding the existence of coverage were incorrect as to any patient."); see also Brief of Plaintiff-Appellant, Access Mediquest v. United Healthcare, No. 10-20868, 2011 WL 1462310, at *8 (November 08, 2011); Reply Brief of Plaintiff-Appellant, Access Mediquest v. United Healthcare, No. 10-20868, 2011 WL 2115681, at *15-*16 & n.2 (April 25, 2011).

asserted by 'an independent, third-party health care provider . . . against an insurer for its negligent misrepresentation regarding the existence of health care coverage.'" Access Mediquip, 2010 WL 3909544, at *3 (citations omitted). Nevertheless, drawing a distinction between negligent representations of the existence of coverage as opposed to misrepresentations "regarding the extent of coverage under an ERISA plan or the manner of processing and disposing of the claim for payment under an ERISA plan," the court reasoned that "Access challenges United's handling and disposition of Access's request for payment for claims covered by an ERISA plan and, therefore, the state law causes of action are preempted." Id. (emphasis added).

On appeal, a panel of this Court affirmed in part, reversed in part, and remanded. Access Mediquip, 662 F.3d at 387. The panel concluded that under Fifth Circuit precedent, ERISA did not preempt Access's state law claims for negligent misrepresentation, promissory estoppel, or violations of the Texas Insurance Code. Id. (citing Mem'l Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 243-46 (5th Cir. 1990); Transitional Hosps. Corp. v. Blue Cross, 164 F.3d 952, 954 (5th Cir. 1999)). The panel reasoned that the claims based on negligent misrepresentation, promissory estoppel, and violations of the Texas Insurance Code were not preempted because:

> [s]tate law claims of the kind asserted in Memorial, Transitional, and this case concern the relationship between the plan and third-party,

> non-ERISA entities who contact the plan administrator to inquire whether they can expect payment for services they are considering providing to an insured. The administrator's handling of those inquiries is not a domain of behavior that Congress intended to regulate with the passage of ERISA.

Access Mediquip, 662 F.3d at 385-86. In response to the district court's conclusion that such claims implicate the plan terms and its administration, the panel concluded that "[c]onsultation of the plans' terms is … not necessary to evaluate whether United's agents' statements were misleading." Id. at 385. Instead, the panel observed, the plaintiff is merely seeking damages caused by relying on the insurer's representations or promises to the plaintiff, which contradicted the insurer's subsequent refusal to reimburse the plaintiff. Id. at 386.

United successfully petitioned for rehearing en banc. The petition argued that the panel decision ignored controlling and conflicting Fifth Circuit precedent, Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d 1286 (5th Cir. 1988) (Hermann I), and Hermann Hosp. v. MEBA Med. & Benefits Plan, 959 F.2d 569 (5th Cir. 1992) (Hermann II), which, it contends, supports the preemption of these claims. Cf. Cypress Fairbanks Med. Ctr Inc. v. Pan-Am. Life Ins. Co., 110 F.3d 280, 283-84 (5th Cir. 1997) (listing cases finding tension between the Hermann decisions and the Mem'l Hospital decision).[2]

[2] The plaintiff did not cross-petition for review of the panel's separate holding affirming the district court's decision that ERISA preempted Access' quantum meruit and unjust enrichment claims on the ground that their resolution would

SUMMARY OF ARGUMENT

Before providing medical services and devices, healthcare providers, like the plaintiff, need to ensure that the patient's insurer will pay for those services and devices. If, in communications between the provider and the insurer, the insurer inaccurately says the patient's treatment is covered by an ERISA plan, and the treatment is then provided (as alleged here), the provider will have no ERISA cause of action or remedy because the provider is not an ERISA entity (i.e., a participant, beneficiary, or fiduciary) with standing to sue under ERISA. 29 U.S.C. § 1132(a). Moreover, an assignment from the patient cannot create an ERISA cause of action where no ERISA coverage exists. See Jamail, Inc. v. Carpenters Dist. Council of Houston Pension & Welfare Trusts, 954 F.2d 299, 302 (5th Cir. 1992). The provider's only recourse in that circumstance, therefore, is to bring a cause of action under state law to enforce the alleged promise of (or hold the insurer responsible for misrepresentations about) payment for its services. Those causes of action, which, as here, may take the form of negligent misrepresentation, promissory estoppel, or insurance law claims, are subject to

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necessarily require interpretation of plan terms. See Access Mediquip, 662 F.3d at 386. Although a grant of the petition for rehearing en banc vacated the panel decision, see 5th Cir. R. 41.3, our understanding is that those claims and the lower courts' rationale for preempting them are not being challenged. Accordingly, the Secretary will express no views on the correctness of that aspect of the decisions below in this brief.

dismissal if preempted by ERISA – a result that would leave the provider with no remedy against the insurer.

The panel's rejection of the defendant's ERISA preemption defense is consistent with the significant majority of federal and state appellate court decisions that have permitted the provider to pursue remedies against the insurer under state law in similar circumstances. Those courts have allowed these kinds of state law claims to proceed because: (1) ERISA does not regulate the plan's relationship with third-party non-ERISA entities at issue in this case; (2) the plaintiff's claim to payment does not implicate the propriety of the defendant's denial of coverage to the plan participant or beneficiary under the terms of the ERISA plan; and (3) the plaintiff's lack of standing to bring an ERISA cause of action means that ERISA preemption would eliminate any remedy for alleged misrepresentations without serving any of ERISA's protective purposes.

Thus, the emerging consensus in the courts is that where a service provider's entitlement to payment is independent from the question of whether the patient or procedure actually was covered under the terms of an ERISA plan, state law claims asserting such right to payment are not subject to ERISA preemption. This Court's decisions in Mem'l Hospital and Transitional Hospitals correctly embody this analysis; Hermann II does not. Accordingly, the en banc Court should resolve the

apparent conflict between those decisions and Hermann II by reaffirming Mem'l Hospital and Transitional Hospitals and endorsing the panel decision.

ARGUMENT

ERISA DOES NOT PREEMPT PLAINTIFF'S STATE LAW CLAIMS, WHICH ARE BASED ON THE DEFENDANT'S INDEPENDENT DUTY UNDER STATE LAW TO PAY FOR SERVICES DEFENDANTS PROMISED TO IMBURSE

A. BACKGROUND LEGAL PRINCIPLES

1. The ERISA Preemption Framework

Section 514(a) of ERISA expressly provides that ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute, 29 U.S.C. § 1144(a). "A law 'relate[s] to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with . . . such a plan." New York State Conference of Blue Cross v. Travelers Ins., 514 U.S. 645, 656 (1995) (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983)).[3] ERISA also preempts causes of action brought under state laws that conflict with substantive ERISA requirements, Boggs v. Boggs, 520 U.S. 833, 841 (1997), or that duplicate, supplement, or supplant the ERISA civil enforcement remedy set forth in section

[3] A specific "reference to" ERISA plans in the state law will also trigger preemption if, through the singling out of ERISA or ERISA plans in the state law, an ERISA plan is "essential to the law's operation" or the law acts "immediately and exclusively" upon an ERISA plan. Cal. Div. of Labor Standards Enforcement v. Dillingham, 519 U.S. 316, 325 (1997); see also Travelers Ins., 514 U.S. at 656. "Reference to" analysis is not implicated by any of the state causes of action at issue in this appeal.

502(a), 29 U.S.C. § 1132(a). See Aetna Health Inc. v. Davila, 542 U.S. 200, 209, 216 (2004).

In considering whether state law is preempted by ERISA, "the starting presumption [is] that Congress does not intend to supplant state law." Travelers, 514 U.S. at 654. Moreover, courts look to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" rather than engage in "uncritical literalism" of the "unhelpful" statutory text. Id. at 655-656; accord Egelhoff v. Egelhoff, 532 U.S. 141, 147 (2001). The overall purpose of ERISA's preemption clause is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." Travelers, 514 U.S. at 657. Accordingly, ERISA generally does not preempt state laws having "'only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability.'" Id. at 661 (citation omitted). On the other hand, ERISA generally does preempt "'state laws dealing with the subject matters covered by ERISA,'" id. at 661 (citation omitted), as well as state laws that "mandate[] employee benefit structures or their administration," id. at 658, such as by "bind[ing] plan administrators to any particular choice," or by "preclud[ing] uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one." Id. at 659-660; see Egelhoff, 532 U.S. at 146-47.

The Fifth Circuit has distilled this analysis to a two-part inquiry: "'(1) whether the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) whether the claims directly affect the relationship among the traditional ERISA entities – the employer, the plan and its fiduciaries, and the participants and beneficiaries.'" McAteer v. Silverleaf Resorts, Inc., 514 F.3d 411, 417 (5th Cir. 2008) (citations omitted). State law claims are normally not preempted if the answer to either of these questions is no, but are preempted if the answer to both questions is yes.

Similar analysis is used to determine whether ERISA's exclusive civil enforcement scheme, at section 502 of the Act, 29 U.S.C. § 1132, preempts state law claims. Under section 502(a), only the Secretary and fiduciaries, participants and beneficiaries have standing to bring ERISA claims. Non-fiduciary service providers are not among the parties who can bring such a claim. Jamail, 954 F.2d at 302. As explained by this Court, therefore, a court must "consider not only whether [the plaintiff's] claims could have been brought under ERISA but also whether [they] arise from a legal duty independent of ERISA." McAteer, 514 F.3d at 418 (citing Davila, 542 U.S. at 210). Thus, claims brought by an ERISA party (typically, a plan participant or beneficiary) seeking to remedy a harm caused by a legal duty arising out of ERISA (e.g., denial of the right to plan benefits) interfere with section 502(a)'s exclusivity and are preempted. However, claims brought to

vindicate a legal duty arising out of state law by a party with no legal standing to bring its own claim under ERISA based on rights that are independent of ERISA do not conflict with or frustrate the purpose of this enforcement scheme and are not preempted.[4] See Weaver v. Empl'rs Underwriters, Inc., 13 F.3d 172, 177 (5th Cir. 1994).

2. Relevant Fifth Circuit Case Law

As previously stated, the panel decision principally relies on the Mem'l Hospital and Transitional Hospitals decisions as relevant precedent for its non-preemption holding. The rehearing petition, however, invokes the Hermann I and Herman II decisions as supporting preemption in this case. En banc review was presumably granted with the aim of reconciling these cases and bringing needed clarity to this area of the law.

In Mem'l Hospital, this Court declined to preempt state law misrepresentation claims brought by a healthcare provider who had been denied

[4] Indeed, ERISA "completely preempts" claims brought in state court under state law that could have been brought as ERISA claims. Complete preemption is a jurisdictional doctrine that allows the removal of claims to federal court and either dismissal of the claims on preemption grounds or their recharacterization as ERISA claims. Davila, 542 U.S. at 209-10; see Franciscan Skemp Healthcare, Inc. v. Central States Joint Bd. Health and Welfare Trust Fund, 538 F.3d 594, 596-98 (7th Cir. 2008). The "complete preemption" doctrine, however, has no applicability to state law claims that could not have been brought as ERISA claims or to cases, like this one, that were brought originally in federal court in conjunction with another federal claim or under diversity jurisdiction.

reimbursement for services rendered to a patient covered under an ERISA plan based on an exclusion for pre-existing conditions. 904 F.2d at 238 & n.1. The Court broadly concluded that:

> [w]e cannot believe that Congress intended the preemptive scope of ERISA to shield welfare plan fiduciaries from the consequences of their acts toward non-ERISA health care providers when a cause of action based on such conduct would not relate to the terms or conditions of a welfare plan, nor affect – or affect only tangentially – the ongoing administration of the plan.

Id. at 250. Likewise, in Transitional Hospitals, the Court was presented with state law claims that an insurer "misrepresented that [the patient's] ERISA plan would reimburse [the third-party hospital] for 100% of [the patient's] hospital bills." 164 F.3d at 953. The Court recognized that for the state law misrepresentation claims, the plaintiff presumed the insurer's decision to pay less than 100% of the bills was in agreement with plan terms. Id. Even in cases where the patient is covered, the Court held that misrepresentation claims related to the extent of that coverage "are not dependent on or derived from [the patient]'s right to recover benefits under the [ERISA] plan," and, therefore, not preempted. Id.

In Hermann I, a third-party healthcare provider pursued ERISA and state law claims as an assignee of the beneficiary "to recover benefits owed to [a plan participant] under the terms of an ERISA-governed welfare benefit plan." 845 F.2d at 1286. The Court held the state law claims to be preempted. Id. at 1290-91. In Hermann II, the plaintiff then asserted state law claims in its own capacity and

not as an assignee against the insurer for a state law claim of negligent misrepresentation concerning coverage. 959 F.2d at 576. The Court, without explanation, read Hermann I broadly as "clearly" holding "that ERISA preempted [the plaintiff's] state law claims irrespective of whether [the plaintiff] brought those claims as an enumerated party under ERISA Section 502(a) or in another capacity." Hermann II, 959 F.2d at 578. Hermann II further held that intervening decisions, Mem'l Hospital and Mackey v. Lanier Collection Agency and Serv., Inc., 486 U.S. 825 (1986), did not alter the "law of the case" as it concerned the non-assigned claims (i.e., those brought as an independent non-enumerated party). Id. at 578-79. It distinguished Mackey on the basis that the Hermann claims were not "run of the mill" tort claims but were "closely related to or intertwined with the operation or the benefits of the plan." Id. And it distinguished Mem'l Hospital on the basis that the distinction Mem'l Hospital draws between assigned and non-assigned claims in its discussion of Hermann I was "dicta." Id.

Thus, to the extent the Hermann decisions (especially Hermann II) point to a different conclusion than did Mem'l Hospital, these decisions are in error, as the later-decided Transitional Hospitals decision already correctly indicates: only claims brought by a healthcare provider on an assignment of claims from a plan participant (i.e., like the ones in Hermann I) are preempted by ERISA; state law claims brought by a provider in its own independent capacity (as in this case) are

not. See Transitional Hospitals, 164 F.3d at 955 ("the analytical framework constructed in Hermann I and Memorial. . . requires, when there is some coverage, that the court take the next analytical step and determine whether the claim in question is dependent on, and derived from the rights of the plan beneficiaries to recover benefits under the terms of the plan"). In fact, Transitional Hospitals expressly declined to preempt claims by medical providers involving misrepresentations about the "extent of coverage" under the plan. See id. (agreeing with Lordmann Enters., Inc. v. Equicor, Inc., 32 F.3d 1529 (11th Cir. 1994), and construing Cypress Fairbanks, 110 F.3d at 284, as not being based on any such distinction).[5]

Therefore, the panel here was correct to fault the district court's treatment of Mem'l Hospital and Transitional Hospitals, which ruled against preemption on

[5] Transitional Hospitals repeatedly refers to Hermann I, describing it as standing for the proposition that "a hospital's state-law claims for breach of fiduciary duty, negligence, equitable estoppel, breach of contract, and fraud are preempted by ERISA when the hospital seeks to recover benefits owed under the plan to a plan participant who has assigned her right to benefits to the hospital." Transitional Hospitals, 164 F.3d at 954. In contrast, it describes Mem'l Hospital as standing for the proposition that "ERISA does not preempt state law when the state-law claim is brought by an independent, third-party health care provider (such as a hospital) against an insurer for its negligent misrepresentation regarding the existence of health care coverage." Id. Notably, however, Hermann II is not mentioned at all in the decision. Instead, the court took care to explain that Mem'l Hospital is not limited to situations where the participant receiving the provider's medical services was not covered at all by an ERISA plan. See Transitional Hospitals, 164 F.3d at 954-955 (discussing Cypress Fairbanks, supra).

facts similar to this case. As the panel explained, there is no basis in law or logic for the "'existence of coverage' versus 'extent of coverage' distinction applied by the district court" in this case. Access Mediquip, 662 F.3d at 384. Mem'l Hospital and Transitional Hospitals, however, are in tension, if not in conflict, with the Court's opinion in Hermann II (which was decided after Mem'l Hospital but before Transitional Hospitals) – tension that the en banc Court can now resolve.

3. Other Circuit and State Decisions

In accord with Transitional Hospitals and in specific reliance on Mem'l Hospital, four circuit courts have held in circumstances similar to this case that ERISA does not preempt a health care provider's state-law misrepresentation claims against a plan or its insurer. See In Home Health, Inc. v. Prudential Ins. Co., 101 F.3d 600, 604 (8th Cir. 1996); The Meadows v. Emp'rs Health Ins., 47 F.3d 1006, 1009 (9th Cir. 1995); Lordmann, 32 F.3d at 1533 (11th Cir.); Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc., 944 F.2d 752, 754-56 (10th Cir. 1991). Agreeing with those circuits, the Seventh Circuit in Franciscan Skemp Healthcare, Inc. v. Central States Joint Bd. Health and Welfare Trust Fund, 538 F.3d 594, 601 (7th Cir. 2008), more recently held that a healthcare provider's state law claims against a self-insured plan for misleading the provider by inaccurately stating that a beneficiary was covered was not "completely preempted" by ERISA. Id. at 595, 599, 601. Therefore, the case was not subject

to removal pursuant to the preemptive force of section 502. See supra note 4. The Seventh Circuit reasoned that these claims "belong[] in state court" because the plaintiff:

> is not bringing these claims as a beneficiary, nor is it standing in the shoes of a beneficiary. It is not arguing about plan terms. It is not seeking to recover plan benefits and even acknowledges that under the plan [the beneficiary] is entitled to nothing. [The plaintiff] is bringing state-law claims based on the alleged shortcomings in the communications between it and [the plan].

Id. at 601. As the Seventh Circuit concluded, "the inherent logic of [the other circuits'] outcomes . . . support[s] the notion that state-law claims brought by third-party healthcare providers, in situations analogous to the one with which we are now faced, are independent of ERISA and not completely preempted." Franciscan, 538 F.3d at 600.[6]

[6] In contrast to the other pre-Davila decisions, the Seventh Circuit engaged in "complete preemption" analysis because the case had been originally removed to federal court under that theory, and thus the question before it was whether it should be remanded to state court under the same theory. Franciscan, 538 F.3d at 595; id. at 597-99 (applying the Davila two-part test); see also Marin General Hosp. v. Modesto & Empire Traction Co., 581 F.3d 941, 950 (9th Cir. 2009) (finding, under Davila, no complete preemption for similar claims). In remanding, the court properly left it to the state court to decide whether section 514 preemption applies. Franciscan, 538 F.3d at 601. However, the Seventh Circuit recognized that "similar underlying policy considerations" inform both types of ERISA preemption analyses in these cases and the court "do[es] not find any concrete reason to suppose that the conclusions reached in these cases have been deemed incorrect by Davila." Id. at 600.

In addition to these five circuits, state appellate courts have endorsed the same rationale to hold that ERISA section 514 does not preempt similar claims.[7] See, e.g., S. Alaska Carpenters Health and Sec. Trust Fund v. Jones, 177 P.3d 844, 853-54 & n.33 (Alaska 2008) (action by employee who was not a plan participant against employer and plan trustees); Alliance Health of Santa Teresa Inc. v. Nat'l Presto Ind., Inc., 113 P.3d at 371-73; Weiser v. United Food and Commercial Workers Unions and Emp'rs Midwest Health Benefits Fund, 653 N.E.2d 51, 53 (Ill. App. Ct. 1995); Brookwood Med. Ctr. v. Celtic Life Ins., 637 So.2d at 1387-390; see also Macon-Bibb County Hosp. Auth. v. Nat'l Treasury Emps. Union, 458 S.E.2d 95, 97 (Ga. 1995) (agreeing with Lordmann in a FEBHA preemption decision).

The only arguably contrary circuit authority is a divided decision from the Sixth Circuit in Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (1991). The majority held the medical provider's promissory estoppel, breach of contract,

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[7] Like Mem'l Hospital, Transitional Hospitals, and this case, these state and federal cases decline to preempt state law misrepresentation claims concerning the "extent of coverage" under the plan, not just the "existence" of any coverage. E.g., Hospice of Metro Denver, Inc., 944 F.2d at 753 (application of pre-existing condition exclusion); Lordmann, 32 F.3d at 1533 (question concerning percentage of covered services payable); In Home Health, Inc, 101 F.3d at 602 (application of maximum benefits cap); Brookwood Med. Ctr. v. Celtic Life Ins. Co., 637 So.2d 1385, 1386 (Ala. Civ. App. 1994) (application of "back or spine" treatment exclusion); Alliance Health of Santa Teresa Inc. v. National Presto Industries, Inc., 113 P.3d 360, 365 (N.M. Ct. App. 2005) (application of limits on psychiatric treatment coverage).

negligent misrepresentation, and breach of good faith claims to be preempted. However, the court acknowledged that the plaintiff's standing to sue was based on the patient-beneficiary's assignment of claims to it. Id. at 1277-278 ("appellants repeatedly relied on the assignment of benefits"). In this respect, it is like Hermann I and unlike this case, Mem'l Hospital, and Transitional Hospitals. The dissent criticized the majority's decision for treating the plaintiff provider as an ERISA beneficiary or participant; instead, the plaintiff, "which is neither a participant nor a beneficiary, claims that [defendant's] representations gave rise to duties outside the plan." Id. at 1285 (Jones, J., dissenting). Agreeing with the dissent, other circuits have rejected and distinguished the Cromwell analysis. E.g., Franciscan, 538 F.3d at 600-01.

Thus, excluding this Court's Hermann II, no circuit, including the Sixth Circuit, has held that ERISA preempts a healthcare provider's non-assigned claims based on an independent duty owed to the provider by the plan or its insurer. Moreover, four circuits (in addition to this Court in Mem'l Hospital and Transitional Hospitals) have explicitly held to the contrary; and a fifth circuit (the Seventh), in agreement with the other circuits, has reached the same conclusion with respect to complete preemption.

B. PREEMPTION ANALYSIS

To "relate to" an ERISA plan under section 514(a) of ERISA, the state-law claims must "directly affect the relationship among the traditional ERISA entities – the employer, the plan and its fiduciaries, and the participants and beneficiaries," and "address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan," McAteer, 514 F.3d at 417. The state-law claims here do not fall within either of those categories. Instead, the remedies they seek are based on generally applicable state laws that stand on independent legal ground from that of ERISA section 502(a)'s civil enforcement scheme. Therefore, they are also not preempted under "conflict" or "complete" preemption analysis in that Access is not an enumerated ERISA party that can bring an ERISA cause of action, and the actions it does bring under state law do not duplicate, supplement or supplant the ERISA remedies in the relevant sense.

1. Access's claims do not implicate relationships between ERISA entities

As a non-fiduciary service provider, Access is not "among the traditional ERISA entities -- the employer, the plan and its fiduciaries, and the participants and beneficiaries," McAteer, 514 F.3d at 417, whose legal actions trigger ERISA preemption. Even if United acted as an ERISA fiduciary when it made its statements about coverage to Access, Access was neither a fiduciary nor a participant/beneficiary, and its claims based on these statements are not preempted

because they do not "directly affect the relationship among the traditional ERISA entities." Id. See also Weaver, 13 F.3d at 177 ("We do not agree that the claims of an independent contractor 'directly affect the relationship between the traditional ERISA entities'"); Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enter., Inc., 793 F.2d 1456, 1467 (5th Cir. 1986) ("[C]ourts are more likely to find that a state law relates to a benefit plan if it affects relations among the principal ERISA entities . . . than if it affects relations between one of these entities and an outside party.").

2. Access's claims do not implicate areas of exclusive ERISA concern

As set forth in the Amended Complaint, the claims allege promissory estoppel, negligent misrepresentation, and violations of state insurance law. Compl. at ¶¶ 38-42, 53-59, 60-82. Each claim derives from a "generally applicable [law] that makes no reference to, [and] indeed functions irrespective of, the existence of an ERISA plan." Ingersoll-Rand v. McClendon, 498 U.S. 133, 139 (1990). ERISA does not govern the representations made by plan insurers to plan service providers. Such communications and the legal obligation arising out of such communications are governed by state law, which has, at most, only an indirect effect on plan administration that "should not suffice to trigger pre-emption." Travelers, 514 U.S. at 662. The state law claims seek only to hold

insurers and administrators, in their representations to third-party service providers, to the requirements and standards of care of state tort or insurance law.

Importantly, the plan provider's state law claims do not challenge the propriety of the defendants' denial of payment under the plan terms or ERISA. Instead, they depend solely on the defendant's representations and promises to Access. See Davila, 542 U.S. at 215 ("'the wording of [respondents'] plans is immaterial' to their claims") (citation omitted); see also supra note 1. Unlike claims typically preempted by ERISA, the violation alleged here does not arise from any rights or obligations established by ERISA or the terms of the ERISA plan but rather, if at all, from an independent state law duty to speak truthfully to a third-party provider. See Davila, 542 U.S at 213. Accordingly, the claims as pleaded concern an "independent legal duty that is implicated by a defendant's actions" unrelated to any violations of plan terms or the ERISA remedies for violations of those terms. Id. at 210. Accord McAteer, 514 F.3d at 417.

Indeed, ten years after Transitional Hospitals, this Court rejected preemption of a contract claim similar to the misrepresentation claims in this case. In Lone Star OB/GYN Assocs. v. Aetna Health Inc., 579 F.3d 525, 530 (5th Cir. 2009), the healthcare provider had a written contract with an ERISA plan's insurer that established the payment structure for covered services but did not dictate what services would be covered under the plan. The Court agreed with other authorities

that state contract claims are not preempted where "the claims are not dependent on interpretation of the plan." Id. at 531 n.5; see id. at 532 (rejecting a "mere reference to plan" standard, relying principally on Davila and Livadas v. Bradshaw, 512 U.S. 107, 123-25 (1994) (Labor Management Relations Act)).

Lone Star's analysis is not limited to state contract actions. Rather, state law claims based on analogous legal duties established by enforceable promises made by an insurer to a provider are also not generally preempted. See Bank Of Louisiana v. Aetna U.S. Healthcare Inc., 468 F.3d 237, 243 & n.9 (5th Cir. 2006) (finding no preemption because the state law claims of detrimental reliance, breach of contract, and misrepresentation do not implicate plan administration nor implicate "an aspect of the relationship [between traditional ERISA entities] that is comprehensively regulated by ERISA"). State courts have recognized the viability of similar negligent misrepresentation claims for almost identical factual circumstances under various state laws. E.g., Hermann Hosp. v. Nat'l Standard Ins. Co., 776 S.W.2d 249, 254 (Tex. Ct. App. 1989); St. Joseph's Hosp. & Med. Ctr v. Reserve Life Ins. Co., 742 P.2d 808, 817 (Ariz. 1987); UCSF-Stanford Health Care v. Hawaii Mgmt Alliance Benefits & Servs., Inc., 58 F.Supp.2d 1162, 1169 (D. Hawai'i 1999).[8]

[8] Several facts may be relevant to the merits of the state law claims but ultimately irrelevant to preemption analysis. See Bank of Louisiana, 486 F.3d at 243 n.8. For example, whether Access justifiably relied on the defendant's representations under

The state causes of action held not to be preempted by the panel in this case also do not interfere with ERISA's remedial scheme because the plaintiff service provider is not an enumerated party under section 502(a) (i.e., it is not a participant, beneficiary, or fiduciary). See Davila, 542 U.S. at 214 n.14; Weaver, 13 F.3d at 177. Although service providers frequently bring claims for benefits under ERISA section 502(a)(1)(B) as assignees of the plan participant or beneficiary's claim, they can only bring their own non-ERISA action where, as here, the claim is not that the participant was covered under the plan, but is instead quite the opposite – that the participant was not covered and the service provider was misled as to this fact. Such state law claims do not "duplicate[], supplement[], or supplant[] the ERISA civil enforcement remedy." Davila, 542 U.S. at 209; see also Franciscan, 538 F.3d at 600-601; In Home Health, 944 F.2d at 1277-278 (distinguishing Cromwell on this basis); Transitional Hospitals, 164 F.3d at 954 (distinguishing Hermann I). Therefore, in asserting this claim, Access is not "standing in the shoes" of an ERISA party, and its claims are not derivative of ones an assignor-ERISA party could have brought. Franciscan, 164 F.3d at 600-601. Accordingly, Access's causes of action exist outside of ERISA's civil enforcement scheme and its preemptive reach. Davila, 542 U.S. at 214; accord E.I. DuPont de Nemours & Co. v. Sawyer, 517 F.3d 785, 797-99 (5th Cir. 2008).

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the circumstances goes to the ultimate merits of whether justifiable reliance is found under state law. E.g., St. Joseph's Hosp., 742 P.2d at 817.

3. Access's claims do not undermine ERISA's purposes

Finally, "the objectives of the ERISA statute," which are the "guide" courts follow to determine whether ERISA preemption applies in accordance with congressional intent, Travelers, 514 U.S. at 656, are not threatened by the state-law claims remaining at issue in this case. Rather, preemption here would unfairly leave third-party providers without any remedies for the insurer's alleged broken promises to pay for their services. Cf. Pegram v. Herdrich, 530 U.S. 211, 237 (2000) (engaging in a pragmatic analysis of preemption). As the circuit courts consistently recognize, preemption of a provider's independent misrepresentation claims would unjustly bar these third parties from exercising their rights under state law, thereby leaving them without any remedy because they lack any standing to pursue those claims under ERISA. E.g., Hospice of Metro Denver, 944 F.2d at 755. As the courts recognize, "[w]hen employers and employees gave up state law causes of action because of ERISA, they received federal causes of action under ERISA in exchange." Lordmann, 32 F.3d at 1533-534. In contrast, if preemption applies here, the third-party providers will exchange their state law causes of action for nothing in return. Id.

Such an unfair result without any evidence of congressional intent is especially unwarranted. Cf. Pegram, 530 U.S. at 237. In Hodges v. Delta Airlines, Inc., the Fifth Circuit sitting en banc declined to preempt a state negligence claim

in a preemption regime (the Airline Deregulation Act) that the Supreme Court has analogized to ERISA's. 44 F.3d 334, 336 (5th Cir. 1995) (en banc) (citing Morales v. Trans World Airlines, Inc., 112 S.Ct. 2031, 2037 (1992)). This Court rejected preemption of the negligence claim because "neither the [Act] nor its legislative history indicates that Congress intended to displace the application of state tort law [to the facts of that case], or that Congress even considered such preemption." Id. at 338. The en banc Court quoted the Supreme Court in Silkwood v. Kerr-McGee Corp., 464 U.S. 238, 251 (1984), which stated that:

> "[t]his silence takes on added significance in light of Congress's failure to provide any federal remedy for persons injured by such conduct. It is difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct."

Hodges, 44 F.3d at 338 & n.9. Applying preemption here, as many courts recognize, would thus improperly create "immunity" without any hint of congressional intent. Compare United Constr. Workers v. Laburnum Constr. Corp., 347 U.S. 656, 663-64 (1954) (rejecting such creation of immunity through preemption), with Crowell, 944 F.2d at 1286 (Jones, dissenting) (recognizing that preemption in these cases would create a form of "immunity" for the insurers). On the other hand, holding that ERISA does not preempt Access's claims comports with ERISA and is supported by the Supreme Court, Fifth Circuit, and persuasive authorities.

Moreover, as several circuits have recognized, preempting the service provider's claims against the plan's insurer in these circumstances would likely harm participants and beneficiaries, and thus undermine ERISA's purposes. "[P]reemption of a third-party provider's independent state law claims would discourage health care providers from treating patients without first evaluating the solvency of each patient or requiring patients to pay in advance the cost of their medical services." In Home Health, 101 F.3d at 606-07; accord The Meadows, 47 F.3d at 1011; Mem'l Hosp., 904 F.2d at 247; see St. Joseph's Hosp., 742 P.2d at 313 (citing testimony from a hospital employee). Without any legal remedies, "health care providers can no longer rely as freely [on representations of health care coverage] and must either deny care or raise fees to protect themselves against the risk of noncoverage. . . . [T]he employees whom Congress sought to protect would find medical treatment more difficult to obtain." Lordmann, 32 F.3d at 1533. Thus, the panel decision is consonant not only with the law of ERISA preemption as set forth by the Supreme Court, other courts in analogous circumstances, and the best-reasoned decisions of this Court, but with ERISA's policy goals in general and its preemption provision in particular.

CONCLUSION

For the reasons set forth above, the Secretary requests the en banc Court to adopt the panel decision's reasoning and holding regarding the non-preemption of the plaintiff's state law claims for promissory estoppel, negligent misrepresentation, and violations of the Texas Insurance Code.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,550 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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Dated: July 11, 2012

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CERTIFICATE OF SERVICE

I hereby certify that I served all counsel and the Court the foregoing brief using the Court's electronic filing system and sent the Court twenty (20) copies in hard copy marked for next day delivery, via UPS, on this the 11th day of July, 2012.

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